PRINTED: 01/18/2018
FORM APPROVED
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8308	A. BUILDING: _____ B. WING _____	01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE SUMNER	140 THORNE BOULEVARD GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A licensure survey was completed 1/8/18 - 1/10/18 at NHC Place Sumner. Deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N 643 SS=F	1200-08-06-.06(3)(l) Basic Services (l) A Nursing Home shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Nursing Home will encourage all staff and independent practitioners to obtain an influenza vaccination; 2. A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at http://tennessee.gov/health/topic/hcf-provider); 3. Education of all employees about the following: (i) Flu vaccination, (ii) Non-vaccine control measures, and (iii) The diagnosis, transmission, and potential impact of influenza; 4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and	N 643	Employees #1, #2, #3, #5 will have documentation that they have been offered the Influenza Vaccine added to their employee file. All employees hired 10/01/17 will have files reviewed to identify any employees who do not have documentation that the Influenza Vaccine has been offered. Employees without this documentation will be followed to ensure vaccine is offered and documentation is place in their health file. Going forward, all newly hired employees will receive offer for Influenza Vaccine upon hiring with new hire paperwork. This will be completed by the Assistant Bookkeeper and the CNT/Staff Development Nurse.	1/31/18

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
1/24/18

STATE FORM 6899 7SAM11 If continuation sheet 1 of 2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8308	A. BUILDING: _____ B. WING _____	01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE SUMNER	140 THORNE BOULEVARD GALLATIN, TN 37066

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N 643	Continued From page 1 5. A statement that the requirements to complete vaccinations or declination statements, shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner ' s designee. This Rule is not met as evidenced by: Based on review of facility employee files and interview, the facility failed to document the Influenza Vaccination for 4 (#1, #2, #3, #5) of 5 employee files reviewed. The findings included: Review of employee files revealed no documentation 4 employees were offered the Influenza Vaccination or signed a declination. Interview with the Director of Nursing on 1/10/18 at 2:30 PM in the Conference Room confirmed the facility failed to provide documentation or a signed declination of the Influenza Vaccination to 4 employees.	N 643		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445519	A. BUILDING _____ B. WING _____	01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE SUMNER	140 THORNE BOULEVARD GALLATIN, TN 37066

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E 000	Initial Comments During document review of the Emergency Preparedness portion of the Life Safety survey conducted on 01/08/2017, no deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 1/26/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.